Advance Directives and the Promotion of Autonomy: a comparative Australian statutory analysis

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1. Introduction

Legislation governing advance directives has been enacted in six out of eight Australian jurisdictions.[1] The main reason for enacting legislation was uncertainty about whether an advance directive made by a competent adult, particularly a directive refusing life-sustaining medical treatment, formed part of Australian common law. The enactment of legislation enshrining common law principles regarding advance directives *should* also have enshrined principles of autonomy as these principles underpin the common law regime. As examined in this article, however, the extent to which Australian legislation promotes autonomy in this important area is questionable.

The common law overseas has been settled for many years. A competent adult is entitled to make a directive refusing life-sustaining medical treatment and, provided the directive was valid and applicable to the medical situation that later arose, had to be followed by medical professionals.[2] In reaching this position, the courts have engaged with two important but conflicting principles: autonomy and the sanctity of life. The principle of autonomy (commonly referred to as a 'right of self-determination') dictates that a competent adult has a right to refuse life-sustaining treatment. On the other hand, the state has an interest in protecting and preserving the lives of its citizens, this interest stemming from the principle of sanctity of life. In the context of refusing life-sustaining treatment, the cases have consistently held that the

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[1] *Consent to Medical Treatment and Palliative Care Act 1995* (SA); *Guardianship and Administration Act 1990* (WA) pt 9B; *Medical Treatment Act 1988* (Vic); *Medical Treatment (Health Directions) Act 2006* (ACT); *Natural Death Act 1989* (NT); *Powers of Attorney Act 1998* (Qld) chap 3.

[2] See, for example, *Re T (adult: refusal of treatment)* [1992] 4 All ER 649, 653; *Airedale NHS Trust v Bland* [1993] AC 789, 864; *Re C* [1994] 1 All ER 819, 824; *Re AK (medical treatment: consent)* [2001] FLR 129, 134; *HE v A Hospital NHS Trust* [2003] 2 FLR 408, [20]; *W Healthcare NHS Trust v H* [2005] 1 WLR 834, 838. In Canada, see *Malette v Shulman* (1990) 67 DLR (4th) 321. In the United States, see, for example, *Schloendorff v Society of New York Hospital* (1914) 211 NY 125, 129-130.

principle of autonomy prevails over that of sanctity of life,[3] whether the individual's refusal of treatment is made contemporaneously or in advance of the medical situation arising.

Although the published academic literature predicted that advance directives would be binding in Australia,[4] until recently, there was been no judicial authority on point.[5] The desire to clarify the law has been one of the driving factors behind the enactment of legislation throughout Australia. In a number of speeches introducing Bills into State and Territory parliaments, reference has been made to the need to make the law certain, both for the benefit of individuals who wish to make an advance directive, and for medical professionals treating those individuals.[6]

A goal of enacting legislation, in addition to clarifying the law, was to promote individual autonomy by facilitating a competent adult making a directive to refuse unwanted medical treatment. Despite this goal, all of the statutes regulate the circumstances in which the advance directive will operate. Such regulation, in one way or another, limits the circumstances in which an advance directive will be effective to ensure medical treatment is not given. For example, regulation exists regarding form, when a directive can be completed, when it will operate, and when it can be disregarded. While some of the restrictions may be justified because they are needed to ensure that a decision to refuse treatment represents the wish of a competent individual, many of the restrictions cannot be justified on this basis. This article argues that many statutory provisions effectively erode a competent individual's right

[3] In the United Kingdom, see, for example, *Re T (adult: refusal of medical treatment)* [1992] 4 All ER 649, 661; *Airedale NHS Trust v Bland* [1993] AC 789, 864; *Re AK (medical treatment: consent)* [2001] FLR 129, 134; *HE v A Hospital NHS Trust* [2003] 2 FLR 408, [30]; *W Healthcare NHS Trust v H* [2005] 1 WLR 834, 838. In Canada, see, for example, *Malette v v Shulman* (1990) 67 DLR (4th) 321, 328.

[4] See, for example, Ian Kerridge, Michael Lowe and Cameron Stewart, *Ethics and law for the health professions* (3rd ed, 2009), 253; Cameron Stewart, 'Advance Directives: Disputes and Dilemmas' in Ian Freckelton and Kerry Petersen (ed), *Disputes and Dilemmas in Health Law* (2006) 38; Janine McIlwraith and Bill Madden, *Health Care and the Law* (4th ed, 2006) 132; John Devereux, *Australian Medical Law* (3rd ed, 2007) 905; Loane Skene, *Law and Medical Practice* (3rd ed, 2008) [5.8], Butterworths, *Halsbury's Laws of Australia*, vol 18 (at 9 September 2009) 280 Medicine, '6 Consent' [280-3025].

[5] In July 2009, the New South Wales Supreme Court declared that a document completed by a competent adult constituted a valid advance directive to refuse kidney dialysis: *Hunter and New England Area Health Service v A* [2009] NSWSC 761.

[6] The parliamentary speeches are considered in section 2 below.

to refuse unwanted medical treatment, and should not form part of a legislative framework.

This article examines the extent to which legislation promotes or erodes an individual's autonomy by exploring three issues. Firstly, the significance of the principle of autonomy both at common law and under the statutory regimes is examined. Secondly, what it means to promote autonomy in the statutory context will be explored. While it is widely accepted that the principle of autonomy should underpin both the common law and legislative regimes, there has been very little consideration about what 'autonomy' means in the context of statutory reform, and what statutory provisions are necessary for, or incompatible with, the attainment of autonomy. Thirdly, after providing an overview of how the legislative schemes operate, the restrictions that exist in the legislation are examined. As part of this analysis, the restrictions will be critiqued against the principle of autonomy.

One final point needs to be made at the outset. While advance directives, both at common law and under most of the statutory regimes, can relate to directives about treatment generally, this article is concerned only with advance directives that refuse life-sustaining medical treatment. This kind of advance directive is the most controversial because of the significant consequences of compliance, namely the death of the individual. It is also this kind of directive for which the principles of autonomy and sanctity of life are brought into sharp conflict, as is reflected in many of the common law decisions.

2. Expressed significance of autonomy in common law and statutory regulation

As mentioned in the introduction, the principle of autonomy underpins legal regulation of a competent individual's right to refuse medical treatment, even if that treatment is needed to sustain his or her life. This is the case both for a contemporaneous refusal of treatment, and for an advance refusal of treatment that is contained in a written or oral advance directive. There are many judicial pronouncements in the United Kingdom and elsewhere that establish and confirm the significance and relevance of autonomy in shaping the common law. One of the

earliest and most famous statements is that of Lord Goff in *Airedale NHS Trust v Bland:*

> First, it is established that the principle of self-determination requires that respect must be given to the wishes of the patient, so that if an adult patient of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests to do so …Moreover the same principle applies where the patient's refusal to give his consent has been expressed at an earlier date, before he became unconscious or otherwise incapable of communicating it …[7]

After much speculation, three Superior Courts in Australia have recently handed down decisions regarding the refusal of life-sustaining medical treatment. In July 2009, the New South Wales Supreme Court in *Hunter and New England Area Health Service v A*[8] (*'Hunter's case'*) declared that a document completed by a competent adult constituted a valid advance directive to refuse kidney dialysis. The effect of the declaration was that the hospital treating the adult was required to comply with the directive and withhold dialysis, even though such action was likely to result in the adult's death. Shortly afterwards, the Western Australian Supreme Court considered the contemporaneous refusal of life-sustaining treatment in the high-profile case of *Brightwater Care Group v Rossiter*[9] (*'Rossiter's case'*). One week after the Western Australian decision, the ACT Supreme Court in *Australian Capital Territory v JT*[10](*'JT's case')* refused to declare that it was lawful to withhold artificial nutrition and hydration from a mentally incompetent patient who had requested that such sustenance cease. In the first two cases, the Justices commented specifically about the importance of the principle of autonomy when a competent adult refuses medical treatment.

In *Hunter's case,* when considering the issue of autonomy and the potential conflict with the principle of sanctity of life, McDougall J reviewed a number of United

[7] [1993] AC 789, 864. These comments have subsequently been referred to in other English decisions including *Re AK (medical treatment: consent)* [2001] FLR 129, 133-134, *Re B (adult: refusal of medical treatment)* [2002] 2 All ER 449, 456; *HE v A Hospital NHS Trust* [2003] 2 FLR 408, [30]. For other judicial statements acknowledging the supremacy of autonomy in decisions about medical treatment, see *Re T (adult refusal of medical treatment)* [1992] 4 All ER 649, 661 and 665 and *W Healthcare NHS Trust v H* [2005] 1 WLR 834, 838.
[8] [2009] NSWSC 761.
[9] [2009] WASC 229.
[10] [2009] ACTSC 105.

Kingdom decisions, as well as a famous American and Canadian decision.[11] After citing extensively from these decisions, his Honour ultimately agreed with the notion that the principle of autonomy should prevail in the context of a competent individual refusing treatment. Interestingly, his Honour intimated (without deciding) that, in fact, conflict may not necessarily exist between the principles of autonomy and sanctity of life where a competent adult refuses treatment. His Honour suggested that this is because the very right to refuse treatment is part of what we value as individuals, and that very right is encompassed by the term 'sanctity of life'. His Honour observed that '[r]ecognition of the right to reject medical treatment does not depreciate the value of life'. Quoting from Robins JA in the famous Canadian case of *Malette v Shulman,*[12] his Honour continued that '[i]ndividual free choice and self-determination are themselves fundamental constituents of life. To deny individuals freedom of choice with respect to their health care can only lessen, and not enhance, the value of life'.[13]

When considering the tension that is said to exist between autonomy and the sanctity of life, his Honour concluded that:

> a proper understanding of society's interest in the preservation of life cannot be considered without taking into account the constituents, or attributes, of life. In a free and democratic society those attributes include the right of autonomy or self-determination.[14]

Rossiter's case involved the contemporaneous request by a competent individual, a quadriplegic, for his medical treatment to cease. Mr Rossiter was unable to take food or water orally, so received hydration and nutrition through a percutaneous endoscopic gastrostomy tube that had been inserted directly into his stomach. Mr Rossiter wanted this treatment to stop, and both he and Bridgewater Care Group (who was responsible for caring for Mr Rossiter) sought declarations about their respective rights and obligations. Martin CJ also considered the significant body of case law that

[11] His Honour also cited from a decision of the South Australian Supreme Court in *F v R* (1983) 33 SASR 189 where King CJ noted at 193 'the paramount consideration that a person is entitled to make his own decisions about his life'. Although this statement was not made in the context of refusing medical treatment, it was endorsed by the High Court of Australia in *Rogers v Whitaker* (1992) 175 CLR 479 at 487 per Mason CJ, Brennan, Dawson, Toohey and McHugh JJ.
[12] (1990) 67 DLR (4th) 321.
[13] Ibid 334.
[14] [2009] NSWSC 761, [16].

exists in common law countries and concluded that Mr Rossiter, possessing the requisite capacity, was entitled to decide on the treatment that he wished to receive or refuse. Further, such a decision had to be respected by the facility caring for him. His Honour referred to the long recognised principle of autonomy and self-determination and observed that an aspect of this principle is the right not to consent to medical treatment, 'even if the failure to treat will result in the loss of the patient's life'.[15] Further, his Honour found that a 'medical practitioner or a service provider who provides treatment contrary to the wishes of a mentally competent patient breaks the law by committing a trespass against the person of that patient'.[16]

JT's case involved a man who was chronically psychotic, suffering from paranoid schizophrenia characterised by religious obsessions. JT had become obsessed with fasting in the belief that this would bring him closer to God. The ACT brought an application for a declaration that it would be lawful not to provide JT with artificial nutrition and hydration except as it was needed for palliative care. Although this declaration was refused on the basis that JT lacked capacity to make a decision about artificial feeding, Higgins CJ cited *Hunter's case* with approval. While not using the language of autonomy, Higgins J noted that a competent adult was able to refuse nutrition even though it would result in his or her death.

Autonomy is also the principle that has underpinned Australian legislation on advance directives. Legislation has been enacted in six of Australia's eight jurisdictions, with only New South Wales and Tasmania relying only on common law regulation. When introducing the various Bills into their respective parliaments, it is clear that the intention of governments has been to promote autonomy by allowing individuals to complete directives refusing treatment that would bind medical professionals should capacity to make medical treatment decisions be lost at a later time.

South Australia was the first Australian jurisdiction to enact legislation, the *Natural Death Act 1983* (SA), which allowed a competent adult to complete a document that refused treatment in advance. The original legislation has subsequently been repealed and replaced by the *Consent to Medical Treatment and Palliative Care Act 1995*

[15] [2009] WASC 229, [26].
[16] [2009] WASC 229, [31].

(SA). In introducing the latter Bill into the Legislative Assembly, the Hon SJ Baker referred to patient autonomy as the 'underlying tenet of the Bill'.[17] He continued:

> The concept of dignity of the individual requires acceptance of the principle that patients can reject unwanted treatment. In this respect, the wishes of the patient should be paramount and conclusive even where some would find their choice personally unacceptable.[18]

It was also stated by the Hon SJ Baker that the legislation 'confirms the common law right to refuse treatment'.[19]

In 1988, the Northern Territory Government introduced the Natural Death Bill 1988, which was modelled largely on the earlier South Australian legislation. In his first reading speech, the then Attorney-General, the Hon DW Manzie commented that the Bill 'will provide a framework that will ensure that any person who so desires will have his or her wishes and rights respected in the circumstances that I have outlined'.[20] The last words are a reference to the fact that advance directives could only be given if the individual was suffering from a terminal illness.

The Victorian legislation was designed to give effect to some of the recommendations made by the Social Development Committee, a Committee established by the Victorian Government to inquire into a number of issues related to treatment of dying patients.[21] The Committee heard from more than 150 witnesses and received almost 1400 written submissions. As a result of its investigations, it observed that many patients 'felt frustrated in having what they regarded as clear refusals to undergo further medical treatment ignored or not acted upon by medical practitioners'. It also observed the reluctance of medical professionals to discontinue treatment where there was any doubt about the patient's competence or wishes. It therefore recommended the enactment of legislation to contain the following features:

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[17] South Australia, *Parliamentary Debates*, House of Assembly, 3 November 1994, 989 (Stephen Baker).

[18] Ibid. Similar comments were made when this Bill was introduced into the Legislative Council: South Australia, *Parliamentary Debates*, Legislative Council, 5 August 1993, 60 (Barbara Wiese).

[19] South Australia, *Parliamentary Debates*, House of Assembly, 3 November 1994, 990 (Stephen Baker).

[20] Northern Territory, *Parliamentary Debates*, Legislative Assembly, 17 August 1998, 3537 (Daryl Manzie).

[21] The Social Development Committee received a reference from the Governor in Council on 17 December 1985. The Second and Final Report of the Committee upon 'Inquiring into Options for Dying with Dignity' was delivered in April 1987.

- Clarification of the existing common law right to refuse medical treatment; and
- Enactment of an offence of medical trespass, to be defined as occurring when a medical practitioner carries out or continues with any procedure or treatment where a competent patient freely and informedly refuses that procedure or treatment; and
- Conferring protection from criminal or civil liability on the part of a medical practitioner who acts in good faith and in accordance with the express wishes of the fully informed, competent patient who refuses medical treatment.[22]

As observed by the Hon EH Walker when the Bill was read in the Legislative Council for the second time, the Bill 'gives effect to these recommendations'.[23]

The ACT enacted the *Medical Treatment (Health Directions) Act 2006* (ACT) relatively recently. This Act replaced the *Medical Treatment Act 1994* (ACT) which first facilitated a competent adult making a direction to refuse treatment. A stated objective of both the (repealed) 1994 and 2006 statute is 'to protect the right of patients to refuse unwanted medical treatment'.[24] As the later Act effectively re-enacted the provisions of the earlier Act relating to advance directives, the parliamentary speeches regarding the 2006 legislation were relatively brief. There was a more detailed debate when the Bill was first introduced into the Legislative Assembly in 1994. The then Attorney-General and Minister for Health, the Hon T Connolly, observed that the Medical Treatment Bill 'essentially clarifies the legal situation in relation to withholding treatment'. [25] The Hon T Connolly referred to the 'very grey legal area' where a doctor ceases medical intervention and allows a patient to die.[26] Coupled with the desire to make the law certain was the Government's intention that there be 'a method by which an individual can make it clear that they do not wish to have intensive interventional treatment and that they wish nature to take its course'.[27] While not using the language of autonomy, it was clear that it was the

[22] These recommendations were also noted by the Legislative Council when introducing the Bill for the second time: Victoria, *Parliamentary Debates*, Legislative Council, 23 March 1988, 333 (Evan Walker), and by the Legislative Assembly when the Bill was read for the second time: Victoria, *Parliamentary Debates*, Legislative Assembly, 5 May 1988, 2166 (Andrew McCutcheon).
[23] Victoria, *Parliamentary Debates*, Legislative Council, 23 March 1988, 333 (Evan Walker). Similar comments were made when this Bill was introduced into the Legislative Assembly: Victoria, *Parliamentary Debates*, Legislative Assembly, 5 May 1988, 2166-2168 (Andrew McCutcheon).
[24] *Medical Treatment Act 1994* (ACT) s 4(a) and *Medical Treatment (Health Directions) Act 2006* (ACT) s 5(a).
[25] ACT, *Parliamentary Debates*, Legislative Assembly, 14 September 1994, 2874 (Terry Connolly).
[26] Ibid.
[27] Ibid.

intention of the Government to give an individual the right to refuse treatment, and to ensure that a medical professional who follows that directive by discontinuing treatment be protected.

Queensland's Powers of Attorney Bill was introduced into Parliament in 1997 and enacted in 1998. One of the stated objectives of the Bill as set out in the Explanatory Notes is 'to enable a person to give directions in relation to their future health care if they are unable to do so for themselves'.[28] When introducing the Bill into Parliament, the then Attorney-General and Minister for Justice, the Hon DE Beanland observed that the legislation allowed an individual to do what he or she has always been entitled to do:

> Just as a person has always been entitled to refuse medical treatment regardless of the consequences, this provision…will enable a person to exercise that right in the future through a direction which takes effect only on their becoming incapable of doing so.[29]

Again, although the Attorney-General did not use the language of autonomy, he did refer to the 'entitlement' of a competent adult to refuse unwanted medical treatment. To this extent, it would appear that the underlying intention of the legislature was to enhance autonomy.

Most recently, the Western Australian Parliament enacted the *Acts Amendment (Consent to Medical Treatment) Act 2006.* The Bill was first introduced into the Legislative Assembly in June 2006 but did not receive Royal Assent until June 2008.[30] The Bill was first introduced into the Legislative Assembly by the Hon JA McGinty, the then Minister for Health. In his second reading speech, the Hon JA McGinty emphasised the need to remove uncertainty in relation to the law and to provide a formal legislative framework to ensure that the wishes of individuals would be carried out. In the course of his speech, he commented in the following terms:

> The principle of personal autonomy is central to the bill. The bill establishes a simple, flexible scheme whereby persons can ensure that, in the event that they become mentally incompetent and require medical treatment for any condition,

[28] Explanatory Notes, Powers of Attorney Bill 1997 (Qld) 1.
[29] Queensland, *Parliamentary Debates*, Legislative Assembly, 8 October 1987, 3687 (Denver Beanland).
[30] At the time of writing, the amending Act had not yet commenced operation.

> including a terminal illness, their consent, or otherwise, to specified treatment can be made clear in an advance health directive …[31]

The above review demonstrates the significance of the principle of autonomy in the context of a competent adult's advance refusal of medical treatment. The paramountcy of the principle has been reiterated in the strongest possible terms in the case law. The principle also underpins legislative reform. While there is variation across the States and Territories regarding the language used when introducing the Bills, there is uniform recognition that legislation is needed to ensure legal certainty in this area, to ensure that a competent adult can refuse treatment in advance of losing capacity, and to ensure that such refusal can be relied upon by medical professionals. Some Parliamentarians expressly refer to the term 'autonomy' while others note that competent adults should be able to refuse medical treatment. Further, most parliamentary speeches recognise that the legislation simply enshrines rights that previously existed under the common law. This recognition is significant because, as outlined earlier, these common law rights are underpinned by the principle of autonomy.

3. Promoting autonomy in legal regulation

The parliamentary debates and, in some cases, the legislation itself reveal the objective of statutory reform. That objective is to clarify the law by legislatively enshrining the existing common law right of a competent adult to give an advance refusal of medical treatment that will bind medical professionals. Such an outcome, as is articulated in those debates, would promote individual autonomy.

The next step is to ask how autonomy, as referred to in the debates and some of the statutes, can best be achieved through legislative reform. It is submitted that achieving this objective requires a consideration of two issues. Firstly, the meaning of 'autonomy' in the context of giving an advance directive that refuses life-sustaining treatment must be clearly articulated. Once the meaning of the term *in this context* is clear, then regulation can be framed to confer and protect the rights that flow from

[31] Western Australia, *Parliamentary Debates*, Legislative Assembly, 21 June 2006, 4061b (Jim McGinty). Similar observations were made when the Bill was introduced into the Legislative Council: Western Australia, *Parliamentary Debates*, Legislative Council, 6 December 2006, 9244b (Sue Ellery).

this principle. This is not a difficult task, given the relatively expansive consideration given to the meaning of autonomy in the common law decisions.

The second step is to consider whether there are any barriers that have hindered compliance with advance directives at common law. If such barriers exist, it would be desirable for legislatures to consider whether those barriers could be addressed through statutory reform. Removing practical barriers that existed at common law should lead to increased compliance with statutory advance directives. As such, individual autonomy would be promoted. These barriers are considered later in this section.

Essence of autonomy at common law

To ensure autonomy is achieved through legislatively enshrining common law principles, it is necessary to articulate the essence of autonomy at common law. In other words, how does the common law promote autonomy in the context of an adult wishing to give an advance directive that refuses life-sustaining treatment? This question is answered by examining the prerequisites that must be satisfied at common law for an advance directive refusing treatment to be binding on a medical professional. Since the decision in *Hunter's case*, the position in Australia, as well as in overseas jurisdictions, is clear. For an advance directive to be binding and to operate in a given situation, the following three elements must be satisfied:

- The adult must have been competent at the time the advance directive was completed. For this requirement to be satisfied, the adult must have had capacity to make the directive, [32] and the ability to communicate that directive in some way.[33]

[32] The meaning of 'capacity' is well understood at common law. A person is regarded as lacking capacity if '[t]he person is unable to comprehend and retain the information which is material to the decision, especially as to the likely consequences of having or not having the treatment in question; [… and] the patient is unable to use the information and weigh it in the balance as part of the process of arriving at a decision': *Re C (adult: refusal of medical treatment)* [1994] 1 All ER 819, 824. This test has been adopted in many subsequent English decisions including *Re MB* [1997] 2 FCR 541, 553-554, *Re B (adult: refusal of medical treatment)* [2002] 2 All ER 449, 459, and by the New South Wales Supreme Court in *Hunter's case* [2009] NSWSC 761, [25].

[33] *R (on the application of Burke) v The General Medical Council* [2004] EWHC 1879 (Admin) 440 (although note that, in overturning the decision, the Court of Appeal suggested caution in relying on aspects of Munby J's judgment in future cases: *R (on the application of Burke) v The General Medical Council* [2005] EWCA Civ 1003 [24]). Further, at common law, an individual is presumed to have capacity to make a decision about health care: *Re T* [1992] 4 All ER 649, 664; *Airedale NHS Trust v Bland* [1993] AC 789, 864, 892; *Re C* [1994] 1 All ER 819, 824; *HE v A Hospital NHS Trust* [2003] 2 FLR 408, 414–415; *Hunter's case* [2009] NSWSC 761, [23]; *Brightwater Care Group (Inc) v Rossiter*

- The directive must have been given by the adult free of undue influence or any other vitiating factor.[34]

- The adult must have intended the directive to have operated in the situation that has ultimately arisen.[35]

In light of *Hunter's case*, it is also clear that the following element need **not** be satisfied:

- The adult must be provided with sufficient information to enable him or her to make an informed decision about whether to refuse treatment.[36]

Practical barriers to recognising advance directives at common law

As discussed earlier, the purpose of the legislation in the various jurisdictions is to enshrine the common law. In doing so, autonomy is promoted. If there is evidence that advance directives are not being followed at common law, however, it is incumbent on legislatures to consider such evidence and, where possible, to insert appropriate statutory provisions to promote compliance. In other words, to the extent that it is possible, the legislation should attempt to remove practical barriers to compliance with advance directives that existed at common law.

[2009] WASC 229, [22]. It should be noted, however, that where the consequences of the health decision are grave, the level of competence that is required is correspondingly high: *Re B* [2002] 2 All ER 449, 472; *Re T* [1992] 4 All ER 649, 661; *Hunter's case* [2009] NSWSC 761, [24].

[34] *Re T* [1992] 4 All ER 649, 669; *Hunter's case* [2009] NSWSC 761, [26].

[35] *Hunter's case* [2009] NSWSC 761, [26]. For example, at common law, an advance directive will not apply if there has been a change of the individual's circumstances which indicates that the adult would not have intended that the advance directive would have operated (as in *HE v A Hospital NHS Trust* [2003] 2 FLR 408); or if the advance directive were based on an incorrect assumption about the facts (as in *Re T* [1992] 4 All ER 649. The circumstances in which a health professional is exused from complying with an advance directive at common law are explored in Lindy Willmott, Ben White and Michelle Howard, 'Refusing Advance Refusals: Advance Directives and Life-Sustaining Medical Treatment' (2006) 30 *Melbourne University Law Review* 211. See also section 10 below.

[36] *Hunter's case* [2009] NSWSC 761, [28]–[30]. In some of the secondary literature, it has been suggested that the requirement for an advance directive to be based on sufficient information is a prerequisite for its validity: see, for example, Ian Kennedy and Andrew Grubb, *Medical Law* (3rd ed, 2000) 2037 and Sabine Michalowski, 'Advance Refusals of Life-Sustaining Medical Treatment: The Relativity of an Absolute Right' (2005) 68 *Modern Law Review* 958, 958. However, this suggestion was expressly rejected by the New South Wales Supreme Court in *Hunter's case* and it can no longer be argued that it reflects the common law. The suggestion that an advance directive must be based on sufficient information to be valid is also contrary to legal principle regarding the refusal of treatment, as explored in Willmott, White and Howard, above n 35. Compare also the comments of Martin CJ in *Rossiter's case* where he expressed the view that a competent individual who was giving a *contemporaneous* refusal of life-sustaining treatment should be given information to assist that person to make his or her decision: [2009] WASC 229, [28]-[32].

(a) Legitimate barriers

One important practical barrier to compliance with advance directives has been revealed in the case law and secondary literature.[37] This barrier is the fact that, at least in some circumstances, medical professionals can be reluctant to adhere to a common law advance directive to withhold or withdraw life-sustaining medical treatment. It is submitted that sometimes the reason that a medical professional will not follow an advance directive is understandable, and perhaps even justifiable. For example, as a matter of principle, a medical professional may be willing to comply with an advance directive, but may have concerns about its validity or applicability in a particular case. This could occur in the following cases:

- The medical professional is not satisfied that an individual had the requisite capacity when he or she completed the advance directive.
- The statements made by an individual may be too vague to provide a medical professional with sufficient confidence that the individual intended treatment to be discontinued in a given situation.
- The medical professional is not satisfied that the individual in fact gave the advance directive as relayed by a family member or friend.

For the purpose of this article, I will refer to these as 'legitimate barriers' to compliance. They are 'legitimate' in the sense that the medical professional is not disrespecting a person's autonomy, but has an understandable concern about whether a competent individual intended the directive to apply in the situation that had arisen.

While the failure to follow an advance directive in such a case may be understandable, the result is that the individual's wishes about treatment are not complied with. If the directive was valid and applicable to the situation that had arisen, the decision not to comply with the directive infringes the principle of autonomy. Regulation that seeks to reduce the concerns that medical professionals have about following an advance directive should result in increased compliance with advance directives. This will promote individual autonomy. Legislative provisions that address these 'legitimate barriers', therefore, are not offensive and can be justified as promoting the principle of autonomy.

[37] These authorities are referred to in appropriate places later in the article.

(b) Illegitimate barriers

On the other hand, it is submitted that some barriers to following advance directives may be *illegitimate.* A medical professional may be unwilling to comply with an advance directive, not because he or she doubts its validity or applicability, but for some other reason. Such illegitimate barriers may include the following:

- The medical professional is philosophically opposed to advance directives that refuse life-sustaining medical treatment.
- It is the policy of the hospital or aged care facility in which the medical professional practises not to be guided by instructions in an advance directive.
- The medical professional is not prepared to follow an advance directive because he or she is aware that the individual did not receive all relevant medical information before giving the directive.
- The medical professional is not prepared to follow an advance directive because he or she is of the view that the directive is contrary to good medical practice.

While these barriers may exist in practice, they are not legally defensible. At common law, a medical professional who refuses to comply with a valid and applicable advance directive may be liable to both criminal and civil sanction.[38] The position should be the same under statute. The legislative regimes should prohibit a medical professional from ignoring an advance directive that refuses treatment on any of the grounds listed above. The corollary to this is equally important. Legislation should not allow a medical professional to ignore an advance directive on any of these grounds. Given that the purpose of legislation is to enshrine the common law (and in doing so, promote the principle of autonomy), provisions which allow an advance directive to be ignored for any of the reasons listed above, or any other reason that is not concerned with the validity or applicability of the advance directive, could not be justified as promoting the principle of autonomy.

Concluding remarks

[38] In England, see *Re F* [1990] 2 AC 1, 73); *Re T (adult: refusal of treatment)* [1992] 4 All ER 649, 664–665; *Airedale NHS Trust v Bland* [1993] AC 789, 866. In Australia, see *Secretary, Department of Health and Community Services (NT) v JWB* (1992) 175 CLR 218, 232.

It is submitted that the preceding discussion provides a touchstone against which statutory regulation should be judged. Legislative provisions that are designed to achieve either of the following goals are justified because they promote the principle of autonomy:

> ***Goal 1:***
> To enshrine established common law principles about when an advance directive will be binding and applicable. Enshrining common law principles will promote the principle of autonomy because that principle underpins the common law governing advance directives.
>
> ***Goal 2:***
> To address legitimate barriers that have prevented or discouraged advance directives from being followed by medical professionals at common law. Legislative attempts to address these practical issues arising under the common law regime will lead to increased compliance with advance directives, therefore promoting autonomy.

Legislative provisions that are designed to achieve any other goal cannot be justified on the basis of promoting autonomy.

A detailed review of the legislative regimes is undertaken in the remainder of this article. The review commences with an overview of all of the statutory regimes followed by a detailed examination of the provisions that affect the validity and operation of an advance directive. This examination will include a critique of whether the relevant legislative provisions can be justified on the basis of autonomy by reference to whether the particular provision aims to achieve either of the goals enunciated above.

4. Statutory regimes – an overview

All statutory jurisdictions allow an individual, at least in some circumstances, to make an advance directive that refuses life-sustaining medical treatment. However, there is considerable variation in the models that are used. Some statutes provide only for the advance *refusal* of treatment,[39] while others provide for advance consent *and*

[39] *Medical Treatment Act 1988* (Vic); *Medical Treatment (Health Directions) Act 2006* (ACT); *Natural Death Act 1989* (NT).

refusal.[40] For this reason, there is also inconsistency in the name given to an advance directive by the various statutes: South Australia refers to the document as an 'anticipatory direction', [41] Western Australia and Queensland as an 'advance health directive',[42] Victoria as a 'refusal of treatment certificate',[43] ACT as a 'health direction'[44] and Northern Territory as a 'notice of direction'.[45]

The legislation in all jurisdictions contain provisions to ensure the adult has capacity to complete the directive and there are no vitiating factors surrounding its execution.[46] All statutes also prescribe formal requirements with which the advance directive must comply including whether the directive needs to be in a prescribed form, signed, dated and witnessed.[47] One jurisdiction also requires the provision of information to an individual who wishes to make an advance directive.[48] Although all jurisdictions allow an advance directive refusing life-sustaining medical treatment to operate in some circumstances, most jurisdictions place significant restrictions on this. In Victoria, an advance directive can only be *completed* if a person is suffering from a current medical condition. In South Australia, the Northern Territory and Queensland, although an advance directive refusing treatment can be completed at any time, it can only operate when an individual is in the terminal stages of a terminal illness (South Australia), suffering from a terminal illness (Northern Territory), or is seriously ill, with that illness or disease being of a specified kind (Queensland). It is only in Western Australia and the ACT that the legislation does not contain restrictions on when an individual's directive refusing life-sustaining treatment can operate.[49]

Most statutes expressly require that an individual's advance directive be complied with, though the statutes generally contain provisions which outline when a medical

[40] *Consent to Medical Treatment and Palliative Care Act 1995* (SA); *Guardianship and Administration Act 1990* (WA) pt 9B; *Powers of Attorney Act 1998* (Qld) chap 3.
[41] *Consent to Medical Treatment and Palliative Care Regulations 2004* (SA) Form 1.
[42] See *Guardianship and Administration Act 1990* (WA) pt 9B and *Powers of Attorney Act 1998* (Qld) s 28 respectively.
[43] *Medical Treatment Act 1988* (Vic) Sch 1.
[44] *Medical Treatment (Health Directions) Act 2006* (ACT) s 7.
[45] *Natural Death Regulations 1989* (NT) Sch.
[46] The requirements regarding validity and vitiating factors are detailed in section 5 below.
[47] These formality requirements are detailed in detail in section 6 below.
[48] These requirements are detailed in detail in section 7 below.
[49] The restrictions contained in each statute are detailed in sections 8 and 9 below.

professional may be justified in departing from the directive. Such factors may include uncertainty regarding the directive or a change of circumstances that have occurred since the individual completed the directive.[50] In Queensland, a medical professional is also excused from following an advance directive where the directive is inconsistent with good medical practice.

A final issue to mention is the relationship between the statutory regimes and the common law, following the enactment of legislation. Prior to legislative reform, it is likely that a competent adult had a common law right to give an advance directive refusing life-sustaining medical treatment.[51] Most of the statutes make reference to the common law position. The legislation in Western Australia and Queensland expressly preserve the common law on advance directives.[52] It should be noted, however, that there is doubt whether the relevant provision in Queensland was effective in preserving the common law in that State.[53] In Victoria, ACT and Northern Territory, while not referring to the common law expressly, the legislation provides that its enactment does not affect other rights that an individual may have to refuse treatment. [54] This, presumably, is a reference to previously-existing common law rights so that, at first glance, the common law right regarding advance directives remains. Despite this, however, it has been suggested that the common law might be negated because of the substitute decision-making regime established by the *Guardianship and Administration Act 1986* (Vic).[55] Although the South Australian legislation is silent on whether the common law is preserved, it is likely that the

[50] The provisions that excuse a medical professional from not following an advance directive are considered in section 10 below.
[51] See above n 4. Note, however, the uncertainty that surrounded the common law as referred to in many of the parliamentary debates that were considered in section 2 above.
[52] *Guardianship and Administration Act 1990* (WA) s 110ZB and *Powers of Attorney Act 1998* (Qld) s 39 respectively.
[53] Despite section 39 *Powers of Attorney Act 1998* (Qld) which purports to preserve the common law, it is likely that, due to a drafting error when enacting Queensland's guardianship regime (comprised of *Powers of Attorney Act 1998* (Qld) and the *Guardianship and Administration Act 2000* (Qld)), the common law regime no longer applies in Queensland: see Ben White and Lindy Willmott, 'Will you do as I ask? Compliance with instructions about health care in Queensland' (2004) 4 *Queensland University of Technology Law and Justice Journal* 77.
[54] *Medical Treatment Act 1988* (Vic) s 4; *Medical Treatment (Health Directions) Act 2006* (ACT) s 6; *Natural Death Act 1989* (NT) s 5.
[55] This appears to be the position taken by the Office of the Public Advocate in Victoria as expressed in the Office of Public Advocate Practice Guidelines, chap 12: Not for Resuscitation, p 12.4 (available at www.publicadvocate.vic.gov.au).

common law would continue unless it was expressly or implicitly repealed.[56] The result is likely to be that in all statutory jurisdictions, with the probable exception of Queensland[57] and the possible exception of Victoria,[58] the common law operates alongside the statutory regimes.

In the following sections of the article, separate attention is given to the different types of regulation that affect advance directives. To more easily facilitate a comparison across statutory jurisdictions, a table summarising the various regulatory provisions appears in an appendix to this article.

5. Requirements of capacity and absence of vitiating factors

At common law, an advance directive will only be binding if it is made by a competent adult. The adult must have had capacity at the time of completion and have been able to communicate his or her formulated treatment directive.[59] It is axiomatic that only a competent individual should be able to complete an advance directive. Respect for individual autonomy only has traction if a person has the ability to make a choice. Competence is therefore a prerequisite for the principle of autonomy to operate. As would be expected, the requirement of competence, though couched in a variety of legal terms, exists in all of the statutes.[60] These legislative provisions can be justified as promoting the principle of autonomy as they aim to achieve goal 1 as outlined in section 3 above. That is, they enshrine a common law principle relating to validity of an advance directive, namely that a person must possess the requisite capacity.

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[56] Cameron Stewart 'The Australian experience of advance directives and possible future directions' (2005) 24 *Australasian Journal on Ageing* S25.
[57] See above n 53.
[58] See above n 55.
[59] See above n 32-33 and accompanying text.
[60] *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 7(1); *Guardianship and Administration Act 1990* (WA) s 110P; *Medical Treatment Act 1988* (Vic) s 5(1)(d); *Natural Death Act 1989* (NT) s 4(1); *Powers of Attorney Act 1998* (Qld) s 42. See also *Powers of Attorney Act 1998* (Qld) Sch 3 definition of 'capacity'. While the position is not free from doubt, it is submitted that the maker of an advance directive must have capacity as defined in sch 3 as well as satisfying the requirements of s 42. For a more detailed discussion of this issue, see Willmott, White and Howard, above n 35. Note that the ACT legislation, instead of requiring the individual to have capacity, provides that a health direction cannot be made by an individual with impaired decision-making capacity: *Medical Treatment (Health Directions) Act 2006* (ACT) s 7(3).

In a similar vein, the common law will not recognise and require adherence to an advance directive if undue influence or another vitiating factor was exerted on the individual at the time of its completion. Again, the failure to recognise the validity of an advance directive completed in such circumstances is consistent with the principle of autonomy. A directive which does not represent a person's true choice cannot be regarded as the autonomous choice of that individual. Four of the six statutes provide for advance directives that have been entered into as a result of some kind of vitiating conduct.[61] As with the issue of capacity, various approaches are taken in regulating such conduct. Regardless of the approach used, however, these legislative provisions can also be justified as promoting the principle of autonomy as they aim to achieve goal 1, as outlined in section 3 above.

6. Requirements of form and witnessing

No requirements regarding formality exist at common law. If an advance directive is valid and is applicable to the medical situation that has arisen, it must be followed. By contrast, the legislation in all States and Territories contain requirements that relate to formal matters, though disparate approaches are taken. At first glance, the imposition of legislative requirements that do not exist at common law would suggest that an individual's autonomy is being eroded. The stated desires of an individual will not receive statutory protection unless there is compliance with the statutory requirements. However, as argued below, if the effect of this regulation is to enshrine common law principles regarding validity and applicability, or to remove legitimate barriers that prevent compliance with an advance directive at common law, such regulation may enhance rather than erode an individual's autonomy.

The nature of statutory regulation relating to form, signature and dating, and witnessing, and whether that regulation promotes or erodes the principle of autonomy are considered next.

[61] *Guardianship and Administration Act 1990* (WA) s 110R; *Medical Treatment Act 1988* (Vic) s 5(1)(b); *Medical Treatment (Health Directions) Act 2006* (ACT) s 20. Compare the *Powers of Attorney Act 1998* (Qld) sch 3 where the definition of 'capacity' includes a reference to 'freely and voluntarily being able to make decisions about a matter'. See n 60 above as to whether the maker of a directive must possess capacity as defined in sch 3. The legislation in South Australia and Northern Territory are silent on the issue of undue influence.

Form

The legislation in all jurisdictions except Queensland requires an advance directive, if made in writing, to be completed in the prescribed form.[62] In Queensland, although the advance directive must be in writing, it 'may', but need not be, in the prescribed form.[63] While the legislative provisions differ across the various jurisdictions, generally speaking, a refusal of treatment that is given in a prescribed form is deemed to constitute a refusal of treatment that can be relied upon by a medical professional.[64]

Little is known about the extent to which common law directives refusing life-sustaining medical treatment that are made by competent adults are followed by medical professionals, or are simply disregarded. One of the criticisms commonly made about the usefulness of advance directives is that they do not provide medical professionals with useful information.[65] An advance directive therefore may not provide helpful guidance regarding a person's desired treatment. This may result in the advance directive being ignored by a medical professional.[66]

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[62] *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 7(2); *Guardianship and Administration Act 1990* (WA) s 110Q(1)(a) although note that it is sufficient if the directive is 'substantially' in the form prescribed by regulations; *Medical Treatment Act 1988* (Vic) s 5(2); *Medical Treatment (Health Directions) Act 2006* (ACT) ss 8 and 21, Approved Form 2007 No 55; *Natural Death Act 1989* (NT) s 4(1). The ACT legislation allows advance directives to be either in writing or oral, so the requirement to be in the prescribed form applies only to a written advance directive: *Medical Treatment (Health Directions) Act 2006* (ACT) ss 7(2) and 8.

[63] *Powers of Attorney Act 1998* (Qld) s 44(2).

[64] *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 7(3); *Guardianship and Administration Act 1990* (WA) s 110S(1); *Medical Treatment Act 1988* (Vic) s 8; *Medical Treatment (Health Directions) Act 2006* (ACT) s 16; *Natural Death Act 1989* (NT) s 4(3). Although the Queensland legislation does not require adherence to a prescribed form, the legislation provides that a direction in an advance health directive has the same effect as if the individual had capacity and provided consent. [In this context, consent includes a refusal of consent to treatment.]: *Powers of Attorney Act 1998* (Qld) s 101.

[65] See, for example, R Dresser, 'Precommitment: A Misguided Strategy for Securing Death With Dignity' (2003) 81 *Texas Law Review* 7; ABI / INFORM Global 1823, 1830-1831; R Dresser, 'Dworkin on Dementia: Elegant theory, questionable policy' (1995) 25 *The Hastings Center Report* 6.

[66] There is some authority to support this proposition. When carrying out its review into a number of issues relating to treatment of dying patients in Victoria, the Social Development Committee referred to practical concerns that may arise that an advance directive may not represent a person's current wishes to discontinue treatment: Parliament of Victoria, Inquiry into Options for Dying and Dignity, Second and Final Report, 1987, 50, 120-121, 196. There is also some support for this proposition in the case law. See, for example, *W Healthcare NHS Trust v H* [2005] 1 WLR 834, a case involving a woman who had indicated that she did not want to be kept alive by machines. The medical professionals were of the view that this directive was not sufficiently clear to justify not reinserting a feeding tube which had been dislodged. The Court of Appeal agreed with the view taken by the medical professionals in this case.

Legislative provisions that prescribe forms (or, at the very least, require an advance directive to be in writing) are likely to result in clearer and more focused directives. The forms used generally direct an individual to answer a specific inquiry. The form prescribed in Queensland is even more particular as it seeks to elicit responses about specific types of treatment. Thus, the completed form is likely to result in more specific instructions being given. The prescribing of forms generally will encourage individuals to think carefully about their wishes regarding treatment, and to translate those wishes into specific instructions. The use of forms therefore may achieve both goals 1 and 2, as articulated in section 3 above. An individual is more likely to complete a valid advance directive which is sufficiently clear so as to indicate treatment choice at a later time. Secondly, the increased clarity may also address a legitimate barrier to compliance by medical professionals. Accordingly, the legislative provisions requiring an advance directive to be in writing or in a prescribed form can be justified as promoting the principle of autonomy.

Signature and date

If the advance directive is in writing, there is a legislative requirement that it must be signed (and generally dated) by the maker of the directive.[67]

It may be the case that some medical professionals are uncomfortable about following a directive if they are unable to satisfy themselves that the directive represents the treatment wishes of the now incompetent patient. Concerns are sometimes also expressed about whether an advance directive represents the current wishes of an individual. Where a medical professional does not have information about when an advance directive was given, he or she may have legitimate concerns about whether the individual retains the views previously articulated in the advance directive.

[67] For the signature requirement, see *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 7(2) and *Consent to Medical Treatment and Palliative Care Regulations 2004* (SA) sch 1; *Guardianship and Administration Act 1990* (WA) s 110Q(1)(c); *Medical Treatment Act 1988* (Vic) s 5(2) and sch 1; *Medical Treatment (Health Directions) Act 2006* (ACT) s 8(a); *Natural Death Act 1989* (NT) and *Natural Death Regulations 1989* (NT) sch; *Powers of Attorney Act 1998* (Qld) s 44(3)(a). For the dating requirement, see *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 7(2) and *Consent to Medical Treatment and Palliative Care Regulations 2004* (SA) sch 1; *Medical Treatment Act 1988* (Vic) s 5(2) and sch 1; *Medical Treatment (Health Directions) Act 2006* (ACT) ss 8 and 21, Approved Form 2007 No 55; *Natural Death Act 1989* (NT) and *Natural Death Regulations 1989* (NT) sch. At the time of writing, a form under the WA legislation has not yet been prescribed, so it is not known whether the person completing the directive will be required to date the document. Compare Queensland where the prescribed form has a provision for the witness, not the individual to insert a date: *Powers of Attorney Act 1998* (Qld) s 44(3)(b).

The requirement that an individual sign and date an advance directive may remove some of this uncertainty or discomfort. From a strictly legal perspective, signing a document traditionally indicates assent to its terms. The signature requirement (combined with the witnessing requirement considered below) may result in a medical professional feeling more confident that the advance directive represents the wishes of the individual. If the advance directive contains a date, this will also provide a level of certainty. For an advance directive completed in the relatively recent past, a medical professional may feel more confident that the directive represented the wishes of the individual before losing capacity. It may therefore be more likely that it is followed. This is not to say that a medical professional is justified in not following an older advance directive. The submission is simply that dating an advance directive, which is required by legislation but not at common law, may have a positive impact on whether a medical professional complies with the directive.

Legislative provisions about signing and dating an advance directive are likely to result in a medical professional having more confidence in the authenticity and currency of the advance directive. This, in turn, may mean that it is more likely that the advance directive is followed by the medical professional. Accordingly, the removal or reduction of a legitimate barrier by requiring the document to be signed and dated can be justified as promotion the principle of autonomy. The regulation aims to achieve goal 2, as outlined in section 3 above.

Witnessing

All statutes also contain witnessing requirements. Generally, the provisions require the witnesses to witness that the advance directive was signed by the individual in their presence.[68] However, in some jurisdictions there are more onerous obligations on a witness, namely to attest to the fact that the individual possessed capacity to

[68] *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 7(1)(2)(b) and *Consent to Medical Treatment and Palliative Care Regulations 2004* (SA) sch 1; *Guardianship and Administration Act 1990* (WA) s 110Q(1)(d) and (e); *Medical Treatment Act 1988* (Vic) s 5(1); *Medical Treatment (Health Directions) Act 2006* (ACT) s 8(c); *Natural Death Act 1989* (NT) s 4(2); *Powers of Attorney Act 1998* (Qld) s 44(3) and (4).

complete the directive [69] and, in some cases, was not the subject of undue influence or other vitiating factor when completing the directive.[70]

It is clearly desirable to ensure that the individual purporting to refuse life-sustaining medical treatment actually did so. The narrower witnessing obligation provides assurance that this is the case. It is also clearly desirable for the person refusing life-sustaining medical treatment to have the requisite capacity to refuse that treatment. While there is a presumption that an adult has capacity to do so,[71] having a witness testify to that fact provides an additional safeguard.

The statutory witnessing requirements can be justified as they achieve both 1 and 2, as outlined in section 3 above. Witnessing a person's capacity is relevant to ensuring the validity of the directive, and is consistent with the objective of ensuring common law principles are legislatively enshrined. In addition, the witnessing requirements will give a medical professional greater confidence that the advance directive was completed by the individual whose name appears on the document. Where the witness testifies as to capacity, the medical professional should take additional comfort that the adult possessed the requisite capacity at the relevant time. For reasons articulated earlier in relation to the signing and dating requirement, the witnessing requirements are likely to make medical professionals more comfortable about following the advance directive. In this way, a further legitimate barrier to complying with an advance directive is removed or decreased. Accordingly, the witnessing requirements can be justified as promoting the principle of autonomy.

Concluding comments

Common law advance directives do not have to satisfy any formal requirements to be valid. To this extent, the requirements imposed by legislation place restrictions on the extent to which an individual's advance directive will operate. However, as discussed above, the formal requirements are primarily designed as a safeguard to ensure that the directive is given by the person stated on the document, and to decrease the scope

[69] *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 7(1)(2)(b) and *Consent to Medical Treatment and Palliative Care Regulations 2004* (SA) sch 1; *Medical Treatment Act 1988* (Vic) s 5(1); *Powers of Attorney Act 1998* (Qld) s 44(3), (4) and (6).
[70] *Medical Treatment Act 1988* (Vic) s 5(1); *Powers of Attorney Act 1998* (Qld) s 44(3), (4) and (6).
[71] See above n 33.

for uncertainty by requiring adherence to a specified form. These provisions assist in enshrining common law principles, and may improve the likelihood that a medical professional will follow the directive. Accordingly, it is submitted that the formality requirements do not offend the principle of autonomy.

7. Requirement to provide information

At common law, an individual does not have to be provided with information about his or her condition or treatment options for an advance directive to be valid or applicable.[72] The same approach is taken in most, but not all statutory jurisdictions. The statutory regimes fall into one of three models. The first model does not impose any prerequisite for the validity of an advance directive that the individual first receive medical information. This model reflects the common law and has been adopted in South Australia, the ACT, the Northern Territory and Queensland.[73] The second model requires medical information to be provided before the advance directive can be witnessed. This model has been adopted only in Victoria.[74] The third model, adopted only in Western Australia, 'encourages' an individual to obtain medical advice prior to completing an advance directive, but failure to seek or receive that advice does not make the advance directive invalid.[75]

The policy underpinning the Victorian requirement that the individual receive information is obvious. It is to ensure that an advance directive to refuse life-sustaining medical treatment is not undertaken lightly, and represents a fully considered desire of a person, such consideration being undertaken after receiving all

[72] See above n 36 and accompanying text.

[73] By way of observation, some of the statutes specifically refer to a medical professional's duty to inform a *competent* patient about treatment options, even if that person has previously made an advance directive: *Medical Treatment (Health Directions) Act 2006* (ACT) s 11 and *Natural Death Act 1989* (NT) s 4(4)**.** In South Australia, while the legislation also imposes on a medical professional a duty to explain medical treatment options either to the patient or the patient's representative, it is unlikely that this provision has any relevance in the context of an advance directive refusing treatment: *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 15.

[74] *Medical Treatment Act 1988* (Vic) s 5(1)(c). An advance directive can only be completed by an individual who has a particular condition, and s 5(1)(c) requires information to be given about the condition to the extent which is reasonably sufficient to enable the patient to make a decision about whether or not to refuse medical treatment. Moreover, s 5(1) requires the witness to be satisfied that the individual has received the information and appeared to understand it.

[75] *Guardianship and Administration Act 1990* (WA) ss 110Q(1)(b) and (2) and 110QA. Note the peculiar drafting of the legislation. Section 110Q(1)(b) provides that an advance directive is not valid unless, among other things, the maker is encouraged to seek legal or medical advice. Section 110Q(2) then provides that, despite s 110Q(1)(b), the validity of the advance directive is **not** affected by a failure to comply with that subsection.

relevant information. To this extent, the state is attempting to safeguard the lives of its citizens, which is one of the principles that is relevant to legal regulation in this field.[76] This safeguard is understandable. However, the question is whether it is sustainable when assessed against the principle of autonomy. To make this assessment, the touchstones against which statutory regulation should be judged, as outlined in section 3 will be used. It will be recalled that legislative regulation could be justified as promoting principles of autonomy if the purpose of the regulation was to promote either goal 1 or goal 2. Each of these goals will be considered in turn.

Goal 1 relates to legislatively enshrining common law principles. If the common law, which is shaped on and driven by principles of autonomy, requires the provision of medical information as a prerequisite for validity of an advance directive, an equivalent statutory provision could be justified. However, this is not the case. While there has been some mixed judicial and academic commentary on whether an advance directive needs to be based on sufficient information,[77] the New South Wales Supreme Court in *Hunter's case* has recently clarified the situation. The Court confirmed that an advance directive will be valid, whether or not an individual receives information prior to its completion. In other words, an advance directive will be valid even if the adult had not received medical information that was relevant to treatment decisions prior to making the directive. Regulation imposing the receipt of information by an adult as a prerequisite to the validity of an advance directive cannot therefore be justified to achieve goal 1.

Legislative reform can also be justified as promoting principles of autonomy if it is designed to remove legitimate barriers that have prevented or discouraged advance directives from being followed by medical professionals, as described in goal 2. A medical professional may feel uncomfortable about following an individual's advance directive unless that person has been fully informed about possible treatment options. A medical professional may also feel uncomfortable about following an advance directive if the person did not have any particular disease or illness at the time the directive was made, and now suffers from such a disease or illness which requires a treatment decision to be made. Clearly, the individual would not have been informed

[76] See section 1 above.
[77] See above n 36.

of the illness or disease as he or she was not suffering from it at the relevant time. However, that discomfort should not influence a medical professional's decision to comply or not comply with the directive. At common law, if the doctor is satisfied that the directive is valid and applicable to the medical situation that has arisen, it must be followed.[78] The doctor does not have any discretion in the matter. If the lack of information was a barrier to following the directive, it would be an illegitimate barrier, as described in section 3. Accordingly, regulation imposing the receipt of information as a prerequisite to the validity of an advance directive cannot be justified to achieve goal 2.

The following example illustrates the infringement on autonomous choice that can result from the Victorian legislation.

> Jack is 65 and has been diagnosed with lung cancer. His father, who Jack nursed for many years, has just died from the same disease. Jack, unlike his father, has decided that he does not want to receive any life-sustaining treatment should he suffer from an acute event. He would rather die quickly than suffer over many years, as did his father. He is competent to make a treatment decision but does not wish to discuss his decision with his doctor.

As demonstrated earlier, legislation was enacted to clarify existing common law rights. The Victorian Government was concerned that the common law was uncertain, and that, in some cases, doctors were reluctant to comply with advance directives. Yet, in the above case, Jack is unable to take advantage of the legislative framework. Jack does not wish to discuss his diagnosis or treatment options, so will be unable to complete the refusal of treatment certificate that is prescribed by the Victorian legislation. It is submitted that imposing this kind of restriction represents an unjustifiable infringement on Jack's autonomy. His choice not to receive information about treatment should be respected, and he should be able to complete a refusal of treatment certificate, and obtain the benefits of the statutory regime.

It is understandable that the state, in this case, Victoria, would like to encourage the provision of information to a competent adult before he or she makes an advance refusal of life-sustaining treatment. As a community, we might feel more comfortable

[78] Note that there are some circumstances in which a medical professional is excused for not following an advance directive. These are explored in section 10 below.

knowing that such a significant decision is reached after an individual has all of the relevant information and has considered all treatment options. However, to take this encouragement one step further and make the provision of information a prerequisite to the operation of an advance directive offends the principle of autonomy. Such a provision cannot be justified as achieving either goal 1 or goal 2, and therefore erodes rather than promotes the principle of autonomy.

8. Circumstances in which an advance directive can be completed

At common law, a competent individual is permitted to complete an advance directive at any time. There is no requirement for the individual to be suffering from a particular disease or illness. This is also the case in all but one statutory jurisdiction. In Victoria, an individual may only complete a 'refusal of treatment certificate' in relation to a 'current condition'.[79] While the certificate enables the person to refuse medical treatment generally or medical treatment of a particular kind, the treatment refused must relate to a current condition.

There is little explanation available from the parliamentary debates regarding why the legislation is limited in this fashion. As has been observed earlier, the Bill was based on recommendations contained in the Report of the Social Development Committee, the Committee charged with inquiring into a number of issues relating to treatment of dying patients. One of the recommendations of the Committee was that the right to refuse treatment should not take the form of an 'advance declaration', namely a 'declaration made while healthy about what should happen if one becomes ill'.[80] When considering this restriction in Parliament, it was observed that 'the Bill allows for the right to refuse treatment to be exercised only within the context of necessary treatment'.[81] There was no further discussion of the reason for limiting the operation of the refusal of treatment certificate in this way.

It is difficult to understand why the Victorian legislation is limited to an individual who has a current condition. One of the objectives of the legislation, as

[79] *Medical Treatment Act 1988* (Vic) s 5(1)(a).
[80] Victoria, *Parliamentary Debates*, Legislative Council, 23 March 1988, 335 (Evan Walker). The same words were used when the Bill was read in the Legislative Assembly for the second time: Victoria, *Parliamentary Debates*, Legislative Assembly, 5 May 1988, 2167 (Andrew McCutcheon).
[81] Victoria, *Parliamentary Debates*, Legislative Council, 23 March 1988, 335 (Evan Walker). See also Victoria, *Parliamentary Debates*, Legislative Assembly, 5 May 1988, 2167 (Andrew McCutcheon).

acknowledged by the Minister for Agriculture and Rural Affairs, the Hon EH Walker, when reading the Bill for the second time in the Legislative Council, was to *clarify* the existing common law right to refuse medical treatment. However, the common law right extends not only to giving instructions about treatment for a *current* condition, but also to giving instructions about treatment for illnesses, diseases or other conditions from which a person may suffer at some time in the future. If the purpose of the legislation was to enshrine this common law right, the legislative regime should not have been restricted to an individual with a current condition.

The Hon EH Walker referred to the findings of the Social Development Committee that many often patients were frustrated because they felt that their 'clear refusals to undergo further medical treatment [were] ignored or not acted upon by medical practitioners'.[82] Similarly, medical professionals were reluctant to act upon those refusals because of concerns about the patient's competence or wishes.[83] The Committee recommended that these concerns be addressed by the completion of a duly witnessed refusal of treatment certificate. The certificate would provide clarity about the patient's wishes, and the witnessing requirements would provide comfort about the patient's capacity. However, these concerns are not logically limited to directives concerning *current* treatment. A Jehovah's Witness, for example, may wish to give directives about refusing blood products and perhaps refusing certain kinds of procedures that are unrelated to a current condition. A medical professional could have similar concerns about the precise nature or ambit of the person's wishes, and whether he or she had competence when the directive was given, or possibly was the subject of undue influence. Nevertheless, such a directive does not fall within the ambit of the legislation. An individual in such a case, therefore, is unable to take advantage of the protection offered by the statutory framework.

The limitation of the Victorian legislation that is considered here is unlike the restrictions considered in other parts of this article. The latter restrictions relate to when an advance directive refusing treatment that is completed by an individual can be followed. The restriction being considered here is that a wide range of individuals are excluded from falling within the scope of the legislation. A person who does not

[82] Victoria, *Parliamentary Debates*, Legislative Council, 23 March 1988, 333 (Evan Walker).
[83] Victoria, *Parliamentary Debates*, Legislative Council, 23 March 1988, 333-334 (Evan Walker).

have a 'current condition' is not permitted to complete a statutory advance directive. Such individuals therefore cannot obtain the benefits of protection of the statutory regime. As was considered in section 2, legislation was enacted because of the lack of certainty regarding whether common law directives would be recognised. Despite the recent decision in *Hunter's case*, it is likely that, in the clinical context, common law directives will still be treated with the same caution as in the past. A person who has not completed a statutory refusal of treatment certificate, therefore, might encounter difficulty in having their advance directive observed. The exclusion of a group of individuals who do not currently suffer from a condition from the ambit of the legislative regime does not promote their right to make an autonomous choice and, therefore, cannot be justified. The statutory regime should be more broadly based, and allow any competent individual the right to complete an advance directive.

9. Circumstances in which an advance directive can operate

It is likely that most individuals would complete an advance directive refusing medical treatment on the assumption that it would be followed, according to its terms, if he or she loses decision-making capacity at a later time, and a decision about treatment needs to be made. Indeed, this is generally the case at common law. However, this is not always the case under the legislation, and the six jurisdictions take a variety of approaches on this point. The legislation in Western Australia and the ACT are the most progressive as they require an advance directive refusing treatment to be followed by medical professionals in all circumstances, if the individual lacks consent and there is a need for a treatment decision to be made.[84] A refusal of treatment certificate completed in accordance with the Victorian legislation must be followed, though, as outlined above, such a certificate can only be completed when the adult suffers from a current medical condition. South Australia, the NT and Queensland also restrict when an advance directive refusing treatment can operate. While the language varies between these three jurisdictions, the person must be close to death before the directive can be followed.[85]

[84] There are, however, circumstances in which the directive need not be followed by a medical professional. These are considered in the next section.

[85] In South Australia, a person must be in the terminal phase of a terminal illness: *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 7(1)(a). 'Terminal phase of a terminal illness' is defined to mean the phase of the illness reached when there is no real prospect of recovery or remission of symptoms (on either a permanent or temporary basis); 'terminal illness' is defined to mean an illness

The variations between jurisdictions will result in different outcomes for individuals in many, if not most, cases where an individual makes an advance directive refusing life-sustaining treatment. The following example is illustrative.

> Mark was diagnosed with dementia when he was 60. He researched the illness and told his family that when he reached the stage of the illness when he was no longer able to make medical decisions for himself, he did not want to receive any life-sustaining medical treatment. Instead, he wanted to be given palliative care and kept comfortable, and be allowed to die. Mark completed an advance directive to that effect.

In Western Australia and the ACT, Mark's directive must be followed as there is no statutory requirement for Mark to be at a particular stage in his illness for it to operate. The position is the same in Victoria. As Mark was suffering from dementia at the time he completed the refusal of treatment certificate, it would be binding.[86] This is not the case for South Australia, the Northern Territory or Queensland. Dementia is a condition that can continue for many years after a person loses his or her decision-making capacity. It is therefore unlikely that the person would satisfy the requirements of the respective statutes regarding when the advance directive could operate. Mark intends his directive to operate as soon as he loses decision-making ability, yet the legislation in those jurisdictions only facilitate it being followed if Mark is in the terminal stage of a terminal illness (or is seriously ill as described in the Queensland legislation). In summary, in the example given, Mark's advance directive

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or condition that is likely to result in death: *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 4. In the Northern Territory, a person must be suffering from a terminal illness: *Natural Death Act 1989* (NT) s 4(1). 'Terminal illness' is defined to mean such an illness, injury or degeneration of mental or physical faculties (a) that death would, if extraordinary measures were not undertaken, be imminent; and (b) from which there is no reasonable prospect of a temporary or permanent recovery, even if extraordinary measures were undertaken. In Queensland, the requirements that must be satisfied before an advance directive to withhold or withdraw a life-sustaining measure can operate are complex. There are two or three requirements (depending on the measure being withdrawn). First, the person must fall within one of the following categories: person has a terminal illness or condition that is incurable or irreversible and as a result of which, in the opinion of a doctor treating the person and another doctor, the person may reasonably be expected to die within 1 year; or the person is in a persistent vegetative state; or the person is permanently unconscious; or the person has an illness or injury of such severity that there is no reasonable prospect that the person will recover to the extent that the person's life can be sustained without the continued application of life-sustaining measures. Secondly, the person has no reasonable prospect of regaining capacity to make a decision about treatment. Thirdly, if the measure is artificial nutrition and hydration, the commencement or continuation of the measure would be inconsistent with good medical practice: *Powers of Attorney Act 1998* (Qld) s 36(2). For a detailed consideration of the restrictions that are imposed by the Queensland legislation, see Lindy Willmott, 'Advance Directives to Withhold Life-Sustaining Medical Treatment: Eroding autonomy through statutory reform' (2007) 10 *Flinders Journal of Law Reform* 287.

[86] See section 8 above.

would be followed in Western Australia, ACT and Victoria, but not in South Australia, the Northern Territory or Queensland.

The question to be asked, then, is whether the restrictions imposed by the legislation in South Australia, the Northern Territory and Queensland can be justified on the basis of promoting an individual's autonomous right to refuse treatment. Parliamentary debates provide some, albeit limited, assistance in establishing the reason for limiting the legislation in this way. The debates in both the Legislative Assembly and the Legislative Council in South Australia simply observe that a person may choose to withhold consent to treatment in the event of suffering a terminal illness.[87] Similarly, in his second reading speech introducing the legislation into the Northern Territory Parliament, the Attorney-General simply observed that a directive could only have effect if death were 'imminent'.[88] Interestingly, later in the speech, the Attorney-General referred to this restriction (along with others contained in the legislation) as 'safeguards'.[89] In Queensland, the Bill that was originally introduced did not contain restrictions about when an advance directive refusing life-sustaining treatment would operate. Amendments were later introduced by the Attorney-General, the Hon DE Beanland. When doing so, he commented that the amendment 'will also guard against the possibility, remote though it may be, of a person attempting to give a direction for the refusal of life-sustaining measures in a situation in which the person's health can be restored by simple medical procedures.'[90]

It is obvious both from the terms of the legislation itself and the limited reference to the restrictions in the various parliamentary debates, that it was the intention of the legislatures that a person's wishes to refuse treatment should only operate when they are close to death. In none of these jurisdictions is any explanation given for this position. The only logical explanation for taking such a position is that the legislatures consider it 'acceptable' for a person who is close to death to refuse

[87] South Australia, *Parliamentary Debates*, Legislative Assembly, 3 November 1994, 990 (Stephen Baker) and South Australia, *Parliamentary Debates*, Legislative Council, 5 August 1993, 60 (Christopher Sumner).
[88] Northern Territory, *Parliamentary Debates*, Legislative Assembly, 17 August 1998, 3537 (Daryl Manzie).
[89] Northern Territory, *Parliamentary Debates*, Legislative Assembly, 17 August 1998, 3538 (Daryl Manzie).
[90] Queensland, *Parliamentary Debates*, Legislative Assembly, 8 October 1987, 3687 (Denver Beanland).

treatment, but not 'acceptable' for a person to refuse such treatment in other circumstances. Applying this reasoning to the example above, the legislatures in these three jurisdictions do not think that it is 'acceptable' to follow Mark's advance directive. He may not be close to death. Mark may be able to live for many years despite his diagnosis of dementia. On the other hand, if Mark was in the terminal phase of cancer, his directive could be followed by medical professionals.

It appears, therefore, that in these three jurisdictions, quality of life assessments are being made. If a person is close to death, it is acceptable that treatment be withheld or withdrawn. In other situations, it is not. Life, in these other situations, should be protected.

The competing principles of autonomy and sanctity of life were considered earlier. It was noted that, under the common law, a competent adult's right to determine medical treatment (which stems from the principle of autonomy) prevails over the interest that the state has in preserving the lives of its citizens (which stems from the principle of sanctity of life). By limiting the circumstances in which an advance directive can be followed, parliaments are altering this balance. In situations where a person is not close to death, the effect of the legislation is to allow the principle of sanctity of life to prevail over the principle of autonomy. This is a surprising position to take, given that in almost all jurisdictions, the legislatures purported to be enshrining common law rights to refuse treatment by enacting the legislation. Instead, in South Australia, Northern Territory and Queensland, the common law rights were selectively (and narrowly) enshrined. An advance directive refusing treatment will not receive the benefit of statutory endorsement if the person is not sufficiently ill. The autonomy of those individuals has been subjugated to the interest of the state in preserving life.

The intention of legislative reform in these three jurisdictions, in relation to when an advance directive that refuses life-sustaining treatment operates, is *not* to enshrine the common law on advance directives (goal 1), nor to remove legitimate barriers that have prevented advance directives from being followed (goal 2). Instead, the intention is to prioritise the principle of sanctity of life over that of autonomy where the person who has made the advance directive is not close to death. To this extent,

the autonomous right of the individual to refuse treatment has been eroded. Such restrictions cannot be justified on principles of autonomy.

10. Circumstances in which an advance directive can be ignored

Even where an advance directive that refuses treatment is valid and operative, at common law there are some circumstances where a medical professional is excused (or prevented) from following it. At common law, the critical issue is whether the maker of the advance directive would have intended it to apply in the situation that has later arisen.[91] There is a range of situations in which the maker of the directive may not have intended the directive to be followed. For example, the circumstances of the person may have changed to the extent that he or she would not have intended the advance directive refusing treatment to apply in the changed circumstances.[92] Secondly, the language of the advance directive might be uncertain and it is impossible for a medical professional to be confident that the person would have wanted the directive refusing treatment to be followed.[93] Thirdly, it is possible that the advance directive was based on incorrect information or assumptions. If the person had been apprised of the correct information, he or she may not have given the directive.[94]

There is considerable statutory divergence regarding the circumstances in which a medical professional is excused for not complying with an advance directive. Not all statutes contain the same excuses, and where there are similar excuses, they are generally couched in different language. Despite this divergence, three broad statutory categories can be identified that justify non-compliance with an advance directive. First, most statutes provide that if the individual intends to revoke the

[91] These circumstances are explored at length in Willmott, White and Howard, above n 35.
[92] See, for example, *HE v A Hospital NHS Trust* [2003] 2 FLR 408 where a Muslim woman who was raised by a Jehovah's Witness completed a formal advance directive refusing blood products. This advance directive was held not to be applicable at a later time because, since completing the advance directive, she had become engaged to a Muslim man and had promised to no longer attend meetings of the Jehovah's Witnesses.
[93] See, for example, *W Healthcare NHS Trust v H* [2005] 1 WLR 834 where a woman had previously said that she did not want to be kept alive by machines. This advance directive was held not to be sufficiently clear to constitute a directive that a percutaneous endoscopic gastrostomy tube not be reinserted after it had been dislodged.
[94] See, for example, *Re T (adult: refusal of medical treatment)* [1992] 4 All ER 649 where a refusal to receive blood products was held not to be a valid refusal as the maker of the statement wrongly assumed that other products would have been a sufficient substitute.

directive but has not yet done so, or has changed his or her mind about the directive, a medical professional would not be required to follow it.[95] Secondly, a number of statutes clearly contemplate that an advance directive refusing treatment may not operate if the circumstances have changed for the maker of the directive since the directive was completed.[96] Thirdly, although only in Queensland, a medical professional is excused from following a directive that is uncertain.[97]

While the statutory provisions that excuse medical professionals from following an advance directive are divergent, they all have one uniting feature. The circumstances contemplated would also allow a medical professional not to follow an advance directive at common law. All of the statutory provisions satisfy the common law test – the maker of the directive would not have intended it to operate in the circumstances that have arisen.

Even those who strongly support the right of an individual to have his or her advance directive followed would agree that an advance directive should not be followed in the circumstances described above. Indeed, it would be inconsistent with principles of autonomy for a medical professional to follow an advance directive that no longer represented the person's wishes. If an advance directive was followed in such a case, the principle of autonomy would be eroded, not promoted. An individual's autonomy will only be advanced if the advance directive represented his or her treatment choice. The common law position is consistent with the principle of autonomy. To the extent

[95] *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 7(3); *Guardianship and Administration Act 1990* (WA) s 110S(6); *Medical Treatment Act 1988* (Vic) s 7(1); *Medical Treatment (Health Directions) Act 2006* (ACT) ss 10(1) and 12; *Natural Death Act 1989* (NT) s 4(3)(a).

[96] In South Australia, an advance directive refusing treatment will only operate if a person is in the terminal phase of a terminal illness or in a persistent vegetative state. Therefore, if a person is no longer in such a condition, the legislation will not apply: *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 7(3). In Western Australia, an advance directive will not apply if there has been a change of circumstances not anticipated by the maker of the directive, and the change of circumstances would have caused a reasonable person to have changed his or her mind: *Guardianship and Administration Act 1990* (WA) s 110S(3). In Victoria, a refusal of treatment certificate will cease to apply if the individual recovers from the condition to which the certificate applies: *Medical Treatment Act 1988* (Vic) s 7(3). In the Northern Territory, an advance directive will only apply if a person is suffering from a terminal illness. Therefore, if the person no longer suffers from that condition, a medical professional will not be able to follow the advance directive: *Natural Death Act 1989* (NT) s 4(3). In Queensland, a medical professional is excused from following an advance directive if he or she has reasonable grounds to believe that circumstances have changed to the extent that the terms of the directive are inappropriate: *Powers of Attorney Act 1998* (Qld) s 103.

[97] *Powers of Attorney Act 1998* (Qld) s 103.

that the statutory provisions referred to above would have the same outcome at common law, they can be justified as achieving goal 1, as outlined in section 3 above.

There is a further excuse that exists in Queensland, however, that cannot be justified on the grounds of autonomy. A medical professional is excused from following a directive if he or she has reasonable grounds to believe that a directive is inconsistent with good medical practice.[98] This provision allows a medical professional to disregard an advance directive refusing treatment if, according to good medical practice, treatment is clinically indicated. The effect of this provision is that the autonomous choice of a competent adult can be overridden on medical grounds, *at the discretion of the medical professional*.[99]

The original Bill did not contain an excuse relating to 'good medical practice'. This amendment was introduced by an independent Member of Parliament, Mrs EA Cunningham. When moving the amendment, she made the following comments:

> This amendment strengthens the argument about the role of the [advance health directive] and where the medical profession has the right to overrule or not comply with the advance health directive. All of the assurances have been given in meetings with the Minister that one overriding factor would continue, and that is the obligation on doctors to act honourably and in accordance with good medical practice. These words reinforce that obligation, that responsibility.[100]

This extract demonstrates the intention of the amendment. An individual's autonomy is overridden if that person's choice is contrary to what is regarded by medical professionals as good medical practice.[101] This position is in sharp contrast with the right of an individual at common law to refuse treatment as described earlier in the article. It is the very heart of the principle of autonomy that a competent adult may make a treatment decision even if others, including medical professionals, disagree with that decision. A decision refusing treatment must be respected even if the reason

[98] *Powers of Attorney Act 1998* (Qld) s 103(1).
[99] Oddly, the medical professional is specifically excused from legal liability if he or she chooses to follow (s 101) *or* chooses not to follow (s 103(2)) the directive.
[100] Queensland, *Parliamentary Debates*, Legislative Assembly, 12 May 1998, 1025 (Liz Cunningham).
[101] It should be noted, however, that this provision may also be relevant if a person is insisting on treatment that a medical professional regards as futile. This alternative purpose was referred to by the then Attorney-General, Denver Beanland, following the introduction of the amendment by Liz Cunningham: Queensland, *Parliamentary Debates*, Legislative Assembly, 12 May 1998, 1025 (Denver Beanland).

for the refusal of treatment is 'rational, irrational, unknown or even non-existent'.[102] As such, the Queensland provision is at odds with the principles of autonomy and cannot be justified. It does not purport to embody a common law exception (goal 1) or remove a legitimate barrier (goal 2) that discourages a medical professional from following it.

11. Conclusions

Statutory advance directive regimes now operate in six of Australia's eight jurisdictions. The major driving factor behind the enactment of legislation was the uncertainty that existed about whether the common law applied in Australia. The central objective of parliaments in enacting legislation, then, was to enshrine existing common law principles. Given that the common law was shaped by the principle of autonomy, and it has been expressly noted that this principle overrides that of sanctity of life in the context of refusal of life-sustaining treatment, it should follow that the legislation also safeguards and promotes the autonomy of competent individuals to refuse such treatment. However, as revealed in this article, this has not occurred. The statutes in most jurisdictions contain restrictions that cannot be justified either as necessary to enshrine common law principles, or to overcome practical barriers that prevented advance directives from being followed at common law.

It is likely that regulation of advance directives will continue to remain on the political agenda for some time. An Advance Care Directives Working Group has been established by the Clinical, Technical and Ethical Principal Committee of the Australian Health Ministers' Advisory Council. The goal of this working group is to move towards greater national consistency.[103] Clearly, a move towards consistency of regulation of advance directives would be desirable.

It is to be hoped that the promotion of autonomy should also be a goal when contemplating legislative reform. If reform is contemplated, careful consideration

[102] *Re T (adult: refusal of medical treatment)* [1992] 4 All ER 649, 664.
[103] See also the recent report issued by the National Health and Hospitals Reform Commission, 'A Healthier Future for All Australians – Final Report', June 2009. While not focusing specifically on advance directives, recommendation 57 in the report was that advance care planning be funded and implemented nationally.

should be given to existing legislative models, the restrictions that they impose, and the effect of those restrictions on the ability of individuals to make an advance refusal of life-sustaining treatment. If future legislators are truly seeking to promote the principle of autonomy, the Western Australian model should be the starting point. The Western Australian legislation regulates capacity, form and witnessing. However, it does not contain restrictions about when an individual can complete a directive, when it will operate, or provisions, over and above those that exist at common law, that excuse a medical professional for not following the directive. This model also encourages an individual to obtain information before completing a directive, but the advance directive is not invalid if the person chooses not to obtain such information.

A competent adult's advance refusal of life-sustaining medical treatment is an entrenched common law right. It constitutes an exercise of that individual's autonomy, and has been upheld on that basis by the courts. Legislative enshrinement of such a right should not derogate from that right. Yet this is currently the position in most statutory jurisdictions. Legislation in this area should seek to replicate or improve on the common law by enshrining the right to refuse life-sustaining medical treatment and, where possible, removing practical barriers that may have hindered the following of an advance directive at common law. Legislative provisions that seek to restrict the scope of the operation of an advance directive in other ways cannot be justified as they erode, rather than promote the principle of autonomy.

	South Australia *Consent to Medical Treatment and Palliative Care Act 1995*	**Western Australia** *Guardianship and Administration Act 1990*	**Victoria** *Medical Treatment Act 1988*	**Australian Capital Territory** *Medical Treatment (Health Directions) Act 2006*	**Northern Territory** *Natural Death Act 1989*	**Queensland** *Powers of Attorney Act 1998*
Capacity	A person … may, while of sound mind, give a direction: s 7(1)	A person who … has full legal capacity may make an advance health directive: s 110P	If … are satisfied that the patient is of sound mind … the registered practitioner and the other person may … witness a … certificate: s 5(1)(d)	… a health direction cannot be made by a person for whom a guardian is appointed … or anyone else who has impaired decision-making capacity: s 7(3)	A person of sound mind … may make a direction: s 4(1)	A principal may make an advance directive … only if the principal understands the … matters [listed]: s 42(1) 'Capacity' … means the person is capable of understanding the nature and effect of decisions …; and freely and voluntarily making decisions …; and communicating the decisions: sch 3
Absence of vitiating factors	---	A treatment decision … is invalid if … is not made voluntarily: s 110R	If … are satisfied that the patient's decision is made voluntarily and without inducement or compulsion … the registered practitioner and the other person	A person must not dishonestly induce someone else to make … a health direction: s 20	---	[See definition of 'capacity' above.]

			may … witness a … certificate: s 5(1)(b)			
Form	A direction must be in the form prescribed by regulation: s 7(2)	An advance directive is not valid unless it is in the form or substantially in the form prescribed by the regulations: s 110Q(1)(a)	A refusal of treatment certificate must be in the form of Sch 1: s 5(2)	If the Minister approves a form for a particular purpose, the approved form must be used for that purpose: s 21(2) [See approved form 2007 No 55.]	A person … may make a direction in the prescribed form: s 4(1)	An advance health directive must be written and may be in the approved form: s 44(2)
Signature and date	[The form appearing in the Regulations contains provision for signature and date.]	An advance directive is not valid unless it is signed by its maker: s 110Q [The legislation does not contain a requirement about date and, at the time of writing, regulations have not been promulgated.]	[The form contains provision for signing and dating by the maker.]	A written health directive is not valid unless it is signed by the maker of the direction: s 8 [Approved form 2007 No 55 contains provision for dating by the maker.]	[The prescribed form contains provision for signing and dating by the maker.]	An enduring document must be signed by the principal: s 44(3) [The prescribed form has provision for the witness, not the principal, to insert a date.]
Witnessing	[The form appearing in the Regulations contains provision for a witness attesting to the fact that the	An advance directive is not valid unless the signature … is witnessed by 2 persons … and it is	If a registered medical practitioner and another person are each satisfied that the patient is of sound	A written health direction is not valid unless the signature is witnessed by 2 other people; and each	A direction … is of no effect unless witnessed by 2 witnesses: s 4(2)	An enduring document must be signed and dated by an eligible witness: s 44(3)

	document was signed in the presence of the witness and that the signer appeared to understand the nature and effect of the direction.]	signed by the witnesses in the presence of its maker and … each other: s 110Q(1)(d) and (e)	mind … the registered medical practitioner and other person may together witness a refusal of treatment certificate: s 5 (1)	witness signs the direction in the presence of the other witness and the person making the direction: s 8		... an enduring document … must include a certificate signed by the witness stating the principal signed … in the witness's presence; and at the time, appeared to the witness to have the capacity necessary to make the enduring document: s 44(4) An advance directive must also include a certificate … by a doctor stating the principal, at the time of making the advance directive, appeared to the doctor to have the capacity necessary to make it: s 44(6)
Requirement to provide information	---	An advance directive is not valid unless the maker is encouraged to seek legal or medical advice: s 110Q(1)(a) Despite subsection	If … are satisfied that the patient has been informed about the nature of his or her condition to an extent which is reasonably sufficient to enable the patient to make a	---	---	---

		(1)(b), the validity of an advance heath directive is not affected by a failure to comply with subsection (1)(b): s 110Q(2)	decision about whether or not to refuse medical treatment generally or of a particular kind … for that condition and that the patient has appeared to understand that information … the registered practitioner and the other person may … witness a … certificate: s 5(1)(c)			
Circumstances in which an advance directive can be completed	---	---	If … are satisfied that a patient has clearly expressed or indicated a decision … for a current condition … the registered practitioner and the other person may … witness a … certificate: s 5(1)(a)	---	---	---
Circumstances in which an advance directive can operate	A person … may … give a direction … about the medical treatment that the person wants … if he or she is at some	---	---	---	A person …who desires not to be subjected to extraordinary measures in the event of his or her suffering	A direction to withhold or withdraw a life-sustaining measure can not operate unless the principal has a

	future time in the terminal phase of a terminal illness, or in a persistent vegetative state: s 7(1)(a)				from a terminal illness, may make a direction: s 4(1)	terminal illness or condition that is incurable or irreversible and …the person may reasonably be expected to die within 1 year; or the person is in a persistent vegetative state … ; or the person is permanently unconscious … ; or the person has an illness or injury of such severity that there is no reasonable prospect that the person will recover to the extent that the person's life can be sustained without the continued application of life-sustaining measures: s 36(2)(a) A direction to withhold or withdraw a life-sustaining measure can not operate unless … for a direction to withhold or withdraw artificial nutrition or artificial hydration - the commencement or

						continuation of the measure would be inconsistent with good medical practice: s 36(2)(b) A direction to withhold or withdraw a life-sustaining measure can not operate unless the person has no reasonable prospect of regaining capacity: s 36(2)(c)
Circumstances in which an advance directive can be ignored	If there is no reason to suppose that the person has revoked, or intended to revoke, the direction, the person is to be taken to have … refused medical treatment: s 7(3) [The direction will only operate if a person is in the terminal phase of a terminal illness: see above. If the condition changes, the direction will not operate.]	… a treatment decision in an advance health directive is taken to have been revoked if the maker of the directive has changed his or her mind about the treatment decision since making the directive: s 110S(6) … a treatment decision in an advance health directive does not operate if circumstances exist or have arisen that the maker of the directive	A refusal of treatment certificate may be cancelled by the person who gave the certificate … clearly expressing or indicating to a registered medical practitioner or another person a decision to cancel the certificate: s 7(1) A refusal of treatment certificate ceases to apply to a person if the medical condition of the person has changed to such an extent that the	A health direction … may be revoked by the person … clearly expressing to a health professional or someone else a decision to revoke the direction: s 10(1)	… where a person … has made a direction … it shall be the duty of that medical practitioner to act in accordance with the direction unless there is reasonable ground to believe that the person has revoked, or intended to revoke, the direction: s 4(3)(a)	This section applies if a health provider has reasonable grounds to believe that a direction in an advance health directive is uncertain or inconsistent with good medical practice or that circumstances, including advances in medical science, have changed to the extent that the terms of the direction are inappropriate: s 103(1) The health provider does not incur any

		would not have reasonably anticipate at the time of making the directive; and would have caused a reasonable person in the maker's position to have changed his or her mind about the treatment decision: s 110S(3)	condition in relation to which the certificate was given is no longer current: s 7(3)			liability, either to the adult or anyone else, if the health provider does not act in accordance with the direction: s 103(2)